Here's some recent e-news that may have some value, it comes from HIPAALIVE. There's some interesting information and opinions....
Enjoy!!!
Ken

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********** hipaalive - legal aspects of HIPAA **********
>>> dfrenkel@usa.capgemini.com 01/31/01 01:25PM >>>

The American Bar Association (ABA) has been holding seminars and has a new health newsletter on the legal aspects of HIPAA.
Look at www.abanet.org.
Dave Frenkel
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********** [hipaalive] RE: Provider/Pt. Conversations in Pt. Rooms *********
From: Tom Hanks [mailto:tom.hanks@beaconpartners.com]
Sent: Monday, January 29, 2001 9:38 AM

I think we're talking about discretion, sensitivity and common sense...
This will be part of the risk avoidance and risk acceptance decisions that are made using the information from the risk assessment.

1) In most semi-private environments (including ER), short of facility redesign - which is probably cost prohibitive - , there may not be a lot that can be done about the potential of Bed A overhearing Bed B's patient-provider interactions.
2) This may fall under the right to disagree or object provision - where the providers ask the patient if it is ok to discuss their PHI in the current environment - if the patient refuses then we may need to figure out a work-around.
3) There needs to be policy for provider-patient interaction in non-emergency semi-private environments that would ensure that another patient's visitors would not be present during those interactions (e.g. a "shoo all the visitors out of the room" policy").
4) Better enforcement of visitor policies and incident reporting procedures - to restrict patient or other hospital visitors from areas where they could overhear patient-provider interactions.
5) In emergency situations it would be up to the providers best professional judgment.
6) In areas such as patient registration, it may be cost-effective to provide privacy paneling and sound barriers.

Thanks,

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-----Original Message-----
From: Jensen, Christine [mailto:CJensen@dhha.org]
Sent: Monday, January 29, 2001 11:01 AM

An issue was raised at a meeting I was at recently. We've all been concerned and will continue to be concerned over those conversations in elevators, halls, cafeterias, etc. But someone brought up provider/pt conversations in semi-private rooms. The patient/visitors at the other

bedside can certainly here the conversation. I'd be interested in thoughts on HIPAA impact on this practice.
Thanks.

Christine Jensen
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********** [hipaalive] American Hosp Assoc **********
>>> dfrenkel@usa.capgemini.com 02/01/01 08:05AM >>>

The American Hosp Assoc(AHA) is stepping up its lobbying, from the AHA email news bulletin, 1/31/01
Dave Frenkel
Principal Consultant
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AHA asks Thompson to reopen, delay HIPAA privacy regs AHA has requested that Health and Human Services Secretary-Designate Tommy Thompson reopen for comment, and thereby delay, the new Health Insurance Privacy and Accountability Act privacy regulations. In a letter to Thompson sent today, Rick Pollack, AHA executive vice president for advocacy and public policy, said the new privacy rules that are to take effect Feb. 26 are neither appropriate nor workable for America's hospitals in many important respects, partially because the cost and scheduled implementation date for the regs are overwhelming. The cost of only three key provisions of the proposed rules would be $4 billion-$22.5 billion and hospitals are expected to be in full compliance by Feb. 26, 2003, according to the letter.
Pollack wrote that adherence to the compliance schedule will be unattainable for many hospitals. Also, many important provisions contained in the new rules were changed unexpectedly and dramatically from the proposed rules and/or in ways that may impede patient care, he said. The letter closed with an affirmation of the AHA's commitment to work with HHS to reform the rules in a way that safeguards patient privacy and patient care.

********** [hipaalive]CONSENTS, AUTHORIZATIONS LEGAL **********
>>> rkraus@shrr.com 02/01/01 09:03AM >>>
Interesting question - we've been looking at it so we can advise the litigation lawyers in our firm as well as a statewide association of litigation attorneys. Here's my thought process:

1. Disclosure is required by 164.502(a)(1)(i) when an individual makes a request for access, inspection and copying under 164.524.

2. The minimum necessary standard does not apply to these types of disclosures to the individual. 164.502(b)(2)(ii).

3. There are no specific requirements for an individual's request for access under 164.524(b)(1). The covered entity may require an individual to make the request in writing (and certainly is well advised to do so).

4. In our state, the state court administrative office has published an form authorization for release of medical information. The form is signed by the individual, identifies the particular provider authorized to release information, describes the information to be released, and identifies the authorized recipients.

It also states the individual's understanding that the information will be made available for inspection and copying to the authorized persons. It also contains the disclosure notice required by our state law governing HIV, AIDS and ARC information.

Finally, the authorization has a specific expiration date, and includes information about revocation. If the authorization is presented along with a subpoena or request for production of records, disclosure of the information is required by law.

The only missing core element for a valid authorization under 164.508(c) is the statement about possible redisclosure by the recipient and loss of protection.

5. The real question is whether a request for medical records by another party, accompanied by the individual's authorization, comes with the access

provisions in 164.524. Nothing in 164.524 appears to preclude an individual from directing that access be provided to another person.

If this comes under 164.524, then the standard court form clearly seems valid. If not, then it seems the form will have to be amended to include the missing core element, as least when disclosure is requested without meeting the other requirements for judicial proceedings in 164.512(e).

A long answer to say that it sure seems that the traditional type of individual authorization should be sufficient, but like with lots of HIPAA questions, we'll have to wait and see.

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********** [hipaalive] NJ Transaction Deadlines **********
>>> Jeanie_Lombardo@horizon-bcbsnj.com 02/01/01 10:08AM >>>

NJ has a law known as HINT "Healthcare Information Networks and Technologies." This law establishes new requirements for the processing of enrollment and claims by health care organizations.

It requires the use of one set of standard enrollment and claims forms for both paper and electronic data exchange; to be developed by state regulators. With regard to the electronic standard, it is the ASCX12N-837 Institutional, Dental and Professional transaction, and the ASCX12N-834 for enrollment.

HINT "may" advance the timetable, in NJ, for implementation of the adopted federal HIPAA standards (indicated above) for only enrollment and claims.

With regard to timing, HINT requires the Commissioner of the DOBI to establish the timetable within 90 days of the date the federal rules on electronic standards are adopted. Under the timetable (which has not yet been proposed) the date for NJ compliance with those HIPAA standards "can" be moved up by 8 to 10 months.

And, yes, NJ can do this legally. It does not change the mandated of HIPAA, it just may advance the timeframe for NJ's compliance.

Jeanie Lombardo
HIPAA Technical Consultant
Horizon BCBSNJ
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********** [hipaalive] RE: TCS:Transaction Standards **********
A provider's system doesn't capture element X. That provider contacts each payer, and they all indicate that they will always ignore element X when loading claims in to their adjudication system.

If element X is required in its segment, and the provider needs to send the segment (either required or situation segment), the provider needs to put at least a dummy value in the element, otherwise it would fail an automated compliance test.

(Aside - receivers of electronic transactions are not required to run EDI transactions through a compliance test, but it makes sense to do it because it can keep prevent bad data from getting to the EDI translation system. Many automated compliance testing tools are available.)

If the element is situational in its segment, but the usage notes indicates that the provider should send it at least some of the time, that is a different matter. Personally, I would put a dummy value. However, it would seem to me that will trading partners could agree to omit the element.

Jonathan Hale
Health New England

-----Original Message-----
From: JONATHAN.SHOWALTER@bcbsne.com
[mailto:JONATHAN.SHOWALTER@bcbsne.com]
Sent: Thursday, February 01, 2001 1:35 PM
To: HIPAAlive Discussion List
Cc: DAFeinberg@computer.org
Subject: [hipaalive] TCS:Transaction Standards

Dave, There are people who believe that two trading partners can agree not to send a segment (for example) that is required in the 837p HIPAA Implementation Guide if they state this in a trading partner agreement. What I have thought and what I hear you say is.... no that is not the case. The implementation guides provided by HIPAA must be followed completely?
Thanks!
Jonathan Showalter
Omaha NE USA

********** [hipaalive] NDC in lieu of HCPCS "J" codes **********
>>> dfrenkel@usa.capgemini.com 02/01/01 03:26PM >>>

from AHA email news 2/1/01:

1) AHA: HIPAA transaction code could pose hardship to providers, payers
The final rule on Transactions and Code Sets required by the Health Insurance Portability and Accountability Act contains ambiguities concerning use of the National Drug Code set for the reporting of drugs and biologic items that could pose significant hardships on both providers and payers. In testimony before the National Committee on Vital and Health Statistics, George Arges, senior director of the AHA's Health Data Management Group and chair of the National Uniform Billing Committee, said the adoption of the NDC in lieu of the HCPCS "J" codes now in use would require extensive conversion and replacement of existing information systems, as well as the associated training costs in working with the new code set. Although the cost would vary according to size of facility, hospital estimates put the price at a minimum of $200,000 per facility.

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